

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10669

## CERTIFICATE OF DEATH

Reg. Dist. N.

10663

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion Station		c. LENGTH OF STAY IN 1b 50 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion Station					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Fred	Middle Ames	Last Ames	4. DATE OF DEATH 9 12 19 61	Month 9	Day 12	Year 19 61	
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/19/1889		9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Minutes 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory		10b. KIND OF BUSINESS OR INDUSTRY Fireman		11. BIRTHPLACE (State or foreign country) Norfolk, Va		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel Ames				14. MOTHER'S MAIDEN NAME Sarah ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mary L. Ames, Marion Station, Md		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Topi Myocarditis</i> 603X DUE TO <i>Urethral Stricture &amp; Chronic bladder</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>obstruction, pyelonephritis, &amp; uremia</i> (c)									
INTERVAL BETWEEN ONSET AND DEATH 4 days Unknown 9 years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>11/2</u> , 19 <u>52</u> , to <u>9/18</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>9/18</u> , 19 <u>61</u> , and that death occurred at <u>2:20</u> P.M., from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>A. A. Barr, M.D.</i>		ADDRESS (Street, city or town, state) <i>Crusfield, Md.</i> DATE SIGNED <i>9/16/61</i>							
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/16/61		22c. NAME OF CEMETERY OR CREMATORIAL John Wesley		22d. LOCATION (City, town, or county) Cottage Grove, Md		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE William H. James Jr. Princess Anne, Md		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 22 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Krause			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEATH CERTIFICATE  
NAME: JOHN D. BROWN 1234567890  
DEATH DATE: 12/31/2023 12:00 PM  
DEATH PLACE: Hospital A 123 Main St, Anytown, USA

BOOK

1234567890

DEATH CERTIFICATE

1234567890

1234567890

1  
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

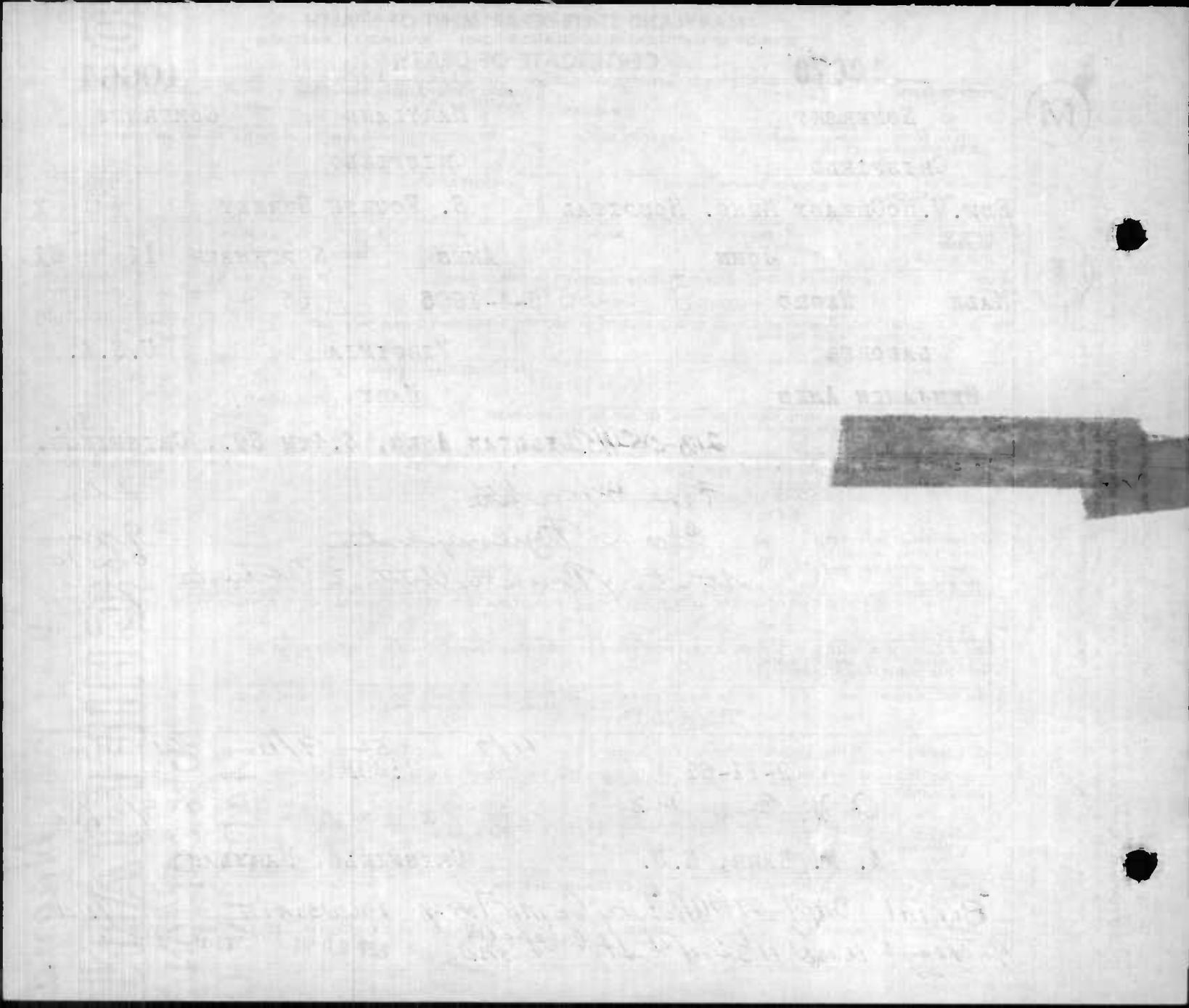
CERTIFICATE OF DEATH

10670

Item 14 Film 0296 9/21/61 iwk

10664

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. McCREADY MEMO. HOSPITAL</b>		d. STREET ADDRESS <b>S. FOURTH STREET</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOHN</b>		First <b>JOHN</b>	Middle <b>AMES</b>
4. DATE OF DEATH <b>SEPTEMBER 11 1961</b>		Month <b>SEPTEMBER</b>	Day <b>11</b>
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>5-4-1906</b>		9. AGE (In years last birthday) <b>56</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BENJAMIN AMES</b>		14. MOTHER'S MAIDEN NAME <b>MARY unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>213-05-4450</b>	
17. INFORMANT <b>ILLIAN AMES, S. 4TH ST., CRISFIELD,</b>		Address <b>Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>612X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Chronic Prostatitis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
(b) DUE TO <b>Chronic Prostatitis</b>		9 year	
(c) DUE TO <b>Stricture of Prostate Urinary Obstruction</b>		5 yrs. 10 years	
19. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>6/1/7</b> to <b>9/11</b> , 1961, that (I) (we) last saw the deceased alive on <b>9-11-61</b> , 1961, and that death occurred at <b>2:20 PM</b> and the causes and on the date stated above.		22b. DATE SIGNED <b>9/12/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. N. BARR, M.D.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>CRISFIELD, MARYLAND</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>SEPT-24-1961</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Holbury Cemetery</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Anthony E. Ward</b>		ADDRESS <b>11 1/2 S. 4th St. Crisfield</b>	23d. LOCATION (City, town, or county) <b>Lawsonia</b>
		25a. REC'D BY REGISTRAR DATE <b>SEP 20 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 10665

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oriole		c. LENGTH OF STAY IN 1b Life Time		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oriole						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mary		First	Middle	Last	4. DATE OF DEATH 9	Month	Day	Year		
5. SEX Female		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH II/7/1884		9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY House Wife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Henry James Maddox		14. MOTHER'S MAIDEN NAME Fannie White								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Oscar Maddox, Oriole, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422/1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Senility		Arteriosclerotic Cardiac Disease				INTERVAL BETWEEN ONSET AND DEATH 15 yrs				
DUE TO Med. Diabetic						15 yrs				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Med. Diabetic						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Princess Anne, Md	(County)	(State)	
21. I certify that I attended the deceased from		OCT.		1955, to Sept 29, 1961, that I last saw the deceased						
alive on		Sept 29, 1961,		and that death occurred at 4 A.M., from the causes and on the date stated above.						
ACTUAL SIGNATURE A.C. Lewis		M.D.		ADDRESS (Street, city or town, state) Princess Anne, Md		DATE SIGNED 9-30-61				
PHYSICIAN'S NAME (Type) A.C. Lewis, M.D.		Princess Anne, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/2/61		22c. NAME OF CEMETERY OR CREMATORIAL St James		22d. LOCATION (City, town, or county) Oriole, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE William H. James Jr. Princess Anne, Md		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 4 '61		24b. REGISTRAR'S SIGNATURE Cirrus S. Kraus				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

51. ~~PROVATATE--FIRMANTE DEL DOCUMENTO QUE CONFIRMA  
CERTIFICACION DE LA~~

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 1 (1166)

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence or town or division) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>		c. LENGTH OF STAY IN 1b <b>Princess Anne</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frank</b>		First <b>Martin</b>	Middle <b>Correia</b>
		Lost	4. DATE OF DEATH <b>September 6</b>
		Month <b>September</b>	Day <b>6</b>
		Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 12, 1901</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Garage</b>	11. BIRTHPLACE (State or foreign country) <b>British Guiana</b>
13. FATHER'S NAME <b>Manuel Correia</b>		14. MOTHER'S MAIDEN NAME <b>Virginia DeSilva</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>150-05-3946</b>	17. INFORMANT <b>Mrs. Mary Correia, Princess Anne, Md.</b>
		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) <i>163X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>15 min.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		<i>Massive hemorrhage from lung</i>	
DUE TO <i>163X</i>		<i>Carcinoma of lungs.</i>	
DUE TO (b)		14 yrs.	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <b>Salisbury</b> (County) <b>Maryland</b> (State) <b>Maryland</b>
21. I certify that I attended the deceased from <b>May</b> , 19 <b>61</b> , to <b>Sept 6</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Sept 6</b> , 19 <b>61</b> , and that death occurred at <b>7:40 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Princess Anne</b> DATE SIGNED <b>Sept 7, 1961</b>	
ACTUAL SIGNATURE <b>B. FRANK GIGANTI</b>		PHYSICIAN'S NAME (Type) <b>B. FRANK GIGANTI</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>Sept. 7, 1961</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Wicomico Memorial</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Hinman</b>		ADDRESS <b>Princess Anne</b>	24a. REC'D BY REGISTRAR DATE <b>SEP 11 '61</b>
			24b. REGISTRAR'S SIGNATURE <b>John S. Hinman</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AT 3900 FT 145° 0.7480724500000001 0.0000000000000000 0.0000000000000000

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**10673 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **106667**

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eden</b>		c. LENGTH OF STAY IN 1b <b>Eden</b>		b. COUNTY <b>Somerset</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Paran Douglas Dashiell</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <b>Eden</b>		
3. NAME OF DECEASED (Type or print) <b>Paran Douglas Dashiell</b>			First	Middle	Last
4. DATE OF DEATH <b>Sept. 25, 1961</b>	Month	Day	Year		
5. SEX <b>male</b>	6. COLOR OR RACE <b>Color</b>	7. MARRIED <b>WIDOWED</b>	NEVER MARRIED <b>DIVORCED</b>	8. DATE OF BIRTH <b>Feb. 9, 1909</b>	9. AGE (In years and birthday) <b>52</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>labor</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Lee Dashiell</b>			14. MOTHER'S MAIDEN NAME <b>Senora Barkley</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>981X</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Ruby Dashiell</b> <b>Eden, Md.</b>	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Bullet wound of chest</b> INTERVAL BETWEEN DUE TO      ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.      (b)      minutes DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)      19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Gunshot wound of chest</b>		20c. TIME OF INJURY      Month, Day, Year <b>5: 30 A.M. 9-25- 1961</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town)      (County)      (State) <b>Eden - Somerset Co. - Maryland</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>R. H. Johnson</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <b>9 - 26- 61</b>	
EXAMINER'S NAME (Type) <b>R. H. Johnson, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>9-28-1961</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Flower Hill Cemetery</b>	22d. LOCATION (City, town, or county) <b>Eden, Md.</b>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonor Wilson</i>	ADDRESS <b>Princess Anne, Md.</b>	24a. REC'D BY REGISTRAR <b>Arthur S. Kline</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10674 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10668

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
Somerset MARYLAND		Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield		b. COUNTY	
c. LENGTH OF STAY IN 1b Lifetime		Somerset	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Jacksonville Road		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First JAMES	Middle HIRAM
3. NAME OF DECEASED (Type or print)		3. NAME OF DECEASED (Type or print)	4. DATE OF DEATH
3. NAME OF DECEASED (Type or print)		3. NAME OF DECEASED (Type or print)	Month Sept.
3. NAME OF DECEASED (Type or print)		3. NAME OF DECEASED (Type or print)	Day 1
3. NAME OF DECEASED (Type or print)		3. NAME OF DECEASED (Type or print)	Year 1961
5. SEX		6. COLOR OR RACE	7. MARRIED
Male		White	NEVER MARRIED <input checked="" type="checkbox"/>
5. SEX		7. MARRIED	8. DATE OF BIRTH
Male		WIDOWED <input type="checkbox"/>	Divorced <input type="checkbox"/>
5. SEX		7. MARRIED	9. AGE (In years last birthday)
Male		WIDOWED <input type="checkbox"/>	63 yrs.
5. SEX		7. MARRIED	10. IF UNDER 1 YEAR Months Days Hours Min.
Male		WIDOWED <input type="checkbox"/>	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		11. BIRTHPLACE (State or foreign country) Tidewater Fisheries Crisfield, Md.	
13. FATHER'S NAME James Dize		14. MOTHER'S MAIDEN NAME Matilda Dize	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-10-1190	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		17. INFORMANT Mrs. Lucial B. Dize— Crisfield, Md.	
420 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Was 100A. on arrival McCready Hospital. Suffered 3 attacks prior to death in a.m. (9-1-61)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20c. TIME OF INJURY Hour a.m. p.m.		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) C. G. Rawley, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Crisfield, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 4, 1961	22c. NAME OF CEMETERY OR CREMATORIAL Mariners Cemetery
22d. LOCATION (City, town, or county) Crisfield, Md.		(State)	
23. FUNERAL DIRECTOR Bradshaw & Sons—Crisfield, Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE SEP 6 '61
23. FUNERAL DIRECTOR Bradshaw & Sons—Crisfield, Md.		ADDRESS	24b. REGISTRAR'S SIGNATURE Arthur S. Trahan

TO DECEASED MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If it is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PAM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
5M 7/59

BP



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 1060

1. PLACE OF DEATH o. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ewell		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ewell		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own home		d. STREET ADDRESS ---		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First CORNELIUS	Middle NICHOLAS	Last EVANS, SR	4. DATE OF DEATH September 18,	Month 19 Year 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 20, 1877	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seafood Packer		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Ewell, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Solomon Evans			14. MOTHER'S MAIDEN NAME Anna Eliza Bradshaw			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Rosamond Smith, Ewell, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 12 hrs.
Cerebral Hemorrhage Carcinomatosis, generalized metastasis Carcinoma annular descending colon						Undetermined Underdetermined
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Parkinson's Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Dec. 15, 1959, to Sept. 17, 1961, that I last saw the deceased alive on Sept. 18, 1961, and that death occurred at 416 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ewell, Maryland						
DATE SIGNED William N. Heffner M.D.						
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) William N. Heffner Ewell, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 22, 1961		22c. NAME OF CEMETERY OR CREMATORIUM Ewell Meth. Cemetery		
22d. LOCATION (City, town, or county) Ewell, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland		24a. REC'D BY REGISTRAR DATE SEP 25 '61		
24b. REGISTRAR'S SIGNATURE Arthur S. Krause						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

DEATH CERTIFICATE  
Name of deceased: **JOHN R. BROWN**  
Age: **67** Sex: **Male** Color: **White**  
Race: **White** Marital Status: **Married**  
Occupation: **Retired** Previous residence: **12345 12th Street, Toledo, Ohio**  
Cause of death: **Heart Disease** Date of death: **12-17-52**  
Place of death: **Home** Time of death: **10:00 P.M.**  
Name of physician: **Dr. John R. Brown** Name of hospital: **None**  
Name of funeral home: **None** Name of coroner: **None**  
Name of physician signing certificate: **Dr. John R. Brown**  
Signature: **John R. Brown**

Date: **12-18-52**Place: **Home**Signature: **John R. Brown**

Died in the State of Michigan on December 17, 1952, at the age of 67 years, 1 month, 10 days.

I declare under penalty of perjury that the foregoing is true and correct.

Signed this 18th day of December, 1952, at Toledo, Ohio.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

10675

10670

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN lb <b>39</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Edw. W. McCready Memorial Hosp.</b>		d. STREET ADDRESS <b>Lawsonia</b>	
3. NAME OF DECEASED (Type or print) <b>Annie</b>		First <b>Hall</b>	Middle <b> </b>
Last <b> </b>		4. DATE OF DEATH <b>September 16</b>	Month Year <b>1961</b>
S. SEX <b>female</b>	6. COLOR OR RACE <b>negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-25-1884</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Joseph Brittingham</b>		14. MOTHER'S MAIDEN NAME <b>Lilly Stevens</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b> </b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Leon Hall</b>
			Address <b>Crisfield, Maryland</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b>			
DUE TO <b>Bronchopneumonia</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <b>Cerebrovascular accident</b> (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>9-15-61</b> to <b>9-16-61</b> , 19, that (I) (we) last saw the deceased alive on <b>9-16-61</b> , 19, and that death occurred at <b>4:50 AM</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles H. Lithgow</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>9/16/61</b>
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Lithgow, M.D.</b>		22d. ADDRESS <b>Crisfield, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur</b>		23b. DATE THEREOF <b>Sept. 20</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>LAWSONIA</b>
23d. LOCATION (City, town, or county) (State) <b>Crisfield, Som. MD</b>		23e. REC'D. BY REGISTRAR <b>SEP 22 1961</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Ward Marion, Md.</b>		ADDRESS	25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>

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FOR STATE  
HEALTH DEPT.

Items 18&21 Film 295

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10677 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10671

1. PLACE OF DEATH

a. COUNTY

Somerset

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Crisfield

c. LENGTH OF STAY IN 1b

12 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

McCready Memorial Hospital

3. NAME OF  
DECEASED  
(Type or print)

First  
WILLIAM

Middle  
DONALD

Last  
LAIRD

4. DATE  
OF  
DEATH  
September  
4, 1961

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

Dec. 25, 1919

9. AGE (In years  
last birthday)

41  
yrs.

10. IF UNDER 1 YEAR  
Months Deyrs

11. IF UNDER 24 HRS.  
Hours Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY

Trucking

11. BIRTHPLACE (State or foreign country)

Tangier, Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Wilson Laird

14. MOTHER'S MAIDEN NAME

Sarah Ann Evans

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give rank or grade of service)

Yes

WW 2

16. SOCIAL SECURITY NO.

217-16-9795

17. INFORMANT

Mrs. Tully Shields, Crisfield, Maryland

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

420.1

*Delayed/awaiting autopsy report/*

DUE TO

Arterio-sclerosis, generalized, marked

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

Subtotal Occlusion of left descending

DUE TO

coronary artery

(c)

INTERVAL BETWEEN  
ONSET AND DEATH

19 1/2 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20e. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

Involved in fight.

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. 2:30  
xx 9/3 1961

20d. INJURY OCCURRED  
While Not While  
at work  at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)  
Crisfield Somerset Md.

21. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and in my opinion  
death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED  
9/7/61

Address (Street, city, town, or county) Crisfield, Maryland

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

9/7/61

22c. NAME OF CEMETERY OR CREMATORI

American Legion Cemetery

22d. LOCATION (City, town, or country)

Crisfield, Maryland

23. FUNERAL DIRECTOR

ADDRESS

Bradshaw & Sons, Crisfield, Maryland

24a. REC'D BY REGISTRAR

DATE SEP 8 '61

24b. REGISTRAR'S SIGNATURE

Charles S. Evans

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a copy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10678

Item 5 Film 6297 9/29/61 mh  
& 9

## CERTIFICATE OF DEATH

Reg. Dist. No. 72

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Revell Neck</b>		c. LENGTH OF STAY IN 1b <b>Life Time</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Revell Neck</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Divola XXX Miles</b>		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/24/1917</b>	9. AGE (In years last birthday) <b>45 1/2 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oyster Shucker</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Bernice Darsey</b>		14. MOTHER'S MAIDEN NAME <b>Mickey Gale</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <b>Elwood Miles. Revell neck, Md</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <b>174X</b> 174X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		<b>Toxemia</b>						<b>5 days</b>			
DUE TO (b)		<b>Generalized Carcinomatosis</b>						<b>5 mo.</b>			
DUE TO (c)		<b>Cancer of Uterus</b>						<b>8 mo.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Revell Neck</b>	(County) <b>Princetown</b>	(State) <b>Md</b>		
21. I certify that I attended the deceased from <b>Sept 17</b> , 1961, to <b>Sept 18</b> , 1961, that I last saw the deceased alive on <b>Sept 17</b> , 1961, and that death occurred at <b>11:05 A.M.</b> from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <b>20 Princetown St</b>			
ACTUAL SIGNATURE <b>B. Frank Giganti</b>								DATE SIGNED <b>9/19/61</b>			
PHYSICIAN'S NAME (Type) <b>B. FRANK GIGANTI</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/23/61</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>St Paul</b>		22d. LOCATION (City, town, or county) <b>Revell Neck, Md</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. James Jr. Princess Anne, Md</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>SEP 27 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Davis</b>					

SI EDITIONS - TURN TO THE TRUTH - STAR OF THE WORLD

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LEADER

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10679

Reg. Dist. No. 10679

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>		c. LENGTH OF STAY IN 1b <b>75 years</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Somerset</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>H. EDWIN MORRIS</b>		First	Middle	Last	4. DATE OF DEATH SEPT. 24 1961	Month	Day	Year	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 11, 1886</b>	9. AGE (In years last birthday) <b>75</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. IF UNDER 24 HRS. Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Storekeeping</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John W. Morris</b>		14. MOTHER'S MAIDEN NAME <b>Clara Colonna</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Clara Morris Princess Anne, Md.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>290.0</b>		DUE TO <b>Acute Coronary Occlusion</b>				INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>			
Conditions, if any, which gave rise to immediate cause (a), slotting the underlying cause last. <b>(b)</b>		DUE TO <b>Pernicious Anemia</b>				years <b>0</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <i>R. H. Johnson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>9 - 26- 61</b>			
EXAMINER'S NAME (Type) <b>R. H. Johnson, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>9-26-61</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Manokin Pres. Cemetery</b>	22d. LOCATION (City, town, or county) <b>Princess Anne, Md.</b>	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lewis Wilson</i>		ADDRESS <b>Princess Anne, Md.</b>	24a. REC'D BY REGISTRAR <b>SEP 28 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

WISCONSIN STATE GOVERNMENT COUNCIL  
WISCONSIN STATE GOVERNMENT COUNCIL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be recorded by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

10680 10674

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Resident before admission) a. STATE <b>MARYLAND</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>302 Broadway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>WALTER</b>	Middle <b>EVERY</b>	Last <b>STERLING</b>		
4. DATE OF DEATH	Month <b>Sept.</b>	Day <b>27</b>	Year <b>1961</b>		
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1884</b>		
9. AGE (In years last birthday) <b>77</b> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seafood Laborer</b>	11. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>	12. BIRTHPLACE (State or foreign country) <b>Crisfield, Md.</b>		
13. FATHER'S NAME <b>George Sterling</b>	14. MOTHER'S MAIDEN NAME <b>Emma Nelson</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	16. SOCIAL SECURITY NO. <b>World War I 215-05-5734</b>	17. INFORMANT <b>Miss Flora Sterling--302 Broadway--Crisfield, Md.</b>	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>					
DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> Unknown					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (We) attended the deceased from <b>Sept. 23, 1961</b> to <b>Sept. 27, 1961</b> , that (I) (we) last saw the deceased alive on <b>Sept. 27, 1961</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.				11:50 P.M.	22b. DATE SIGNED <b>9-28-61</b>
22a. SIGNATURE <b>C. G. Rawley</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>9-28-61</b>
22c. PHYSICIAN'S NAME (Type) <b>C. G. Rawley, M.D.</b>				22d. ADDRESS <b>Crisfield, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Sept. 30, 1961</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>American Legion Cemetery</b>	23d. LOCATION (City, town, or county) <b>Crisfield, Md.</b>	(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>				25a. REC'D BY REGISTRAR <b>OCT 2 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Charles S. Trahan</b>



1  
FOR STATE  
HEALTH DEPT.

M

Today is necessary, if  
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10681 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10675

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Hill		b. COUNTY Somerset	
c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Hill	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Samuel		First	Middle
4. DATE OF DEATH September 28, 1961		Last	Month Dey Year
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Dec. 27, 1903
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Stevenson		14. MOTHER'S MAIDEN NAME Eveary Harman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address Virginia Ward - Upper Hill, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c)		Acute Coronary Heart Disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 10/4/61	
ACTUAL SIGNATURE R. H. Johnson, M.D.		EXAMINER'S NAME (Type) R. H. Johnson, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/4/61	22c. NAME OF CEMETERY OR CREMATORIAL John Wesley Cemetery
23. FUNERAL DIRECTOR William H. James, Jr. - Princess Anne, Md.		ADDRESS 24a. REC'D BY REGISTRAR DATE OCT 9 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

65803-

10/12/2011

1

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10682 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10676

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it on a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)  
5M 9/55

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eden</b>		c. LENGTH OF STAY IN lb <b>20 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eden</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>Joan</b>	Middle <b>Dashiell</b>	Last <b>Tull</b>	4. DATE OF DEATH <b>Sept. 25, 1961</b>	Month Day Year	Day Year
S. SEX <b>female</b>	6. COLOR OR RACE <b>color</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 19, 1938</b>	9. AGE (In years last birthday) <b>23 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>labor</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Paran Dashiell</b>		14. MOTHER'S MAIDEN NAME <b>Ruby King</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Ruby Dashiell</b>		Address <b>Eden, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured skull</b>							
DUE TO (b) <b>Fractures of left temporal, frontal, parietal,</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>983X</b>							
DUE TO (c) <b>and maxillary bones. Fractures mandible rt. side.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck with heavy object</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 5:10 9-25- 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) (County) (State) <b>Eden - Somerset County-Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>R. H. Johnson</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <b>9-26-61</b>			
EXAMINER'S NAME (Type) <b>R. H. Johnson, M.D.</b>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>9-28 61</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Flowers Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Eden, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Levins Wilson</i>	ADDRESS <b>Princess Anne, Md.</b>	24a. REC'D BY REGISTRAR <b>SEP 28 '61</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

THE STATE OF OKLAHOMA  
REGULAR SESSION

THE STATE OF OKLAHOMA  
REGULAR SESSION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10683

## CERTIFICATE OF DEATH

Reg. Dist. No. 10677

1. PLACE OF DEATH  
a. COUNTY

SOMERSET

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

UPPER Fairmount

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

Md

SOMERSET

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X UPPER Fairmount

d. NAME OF HOSPITAL (If not in Hospital, give street address)

OR INSTITUTION

Penitentiary

d. STREET ADDRESS

1 P.O. Box 123

e. IS RESIDENCE  
ON A FARM?  
YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First: OTIS

Middle: I.

Last: WATERS

4. DATE  
OF  
DEATH

Sept

28

Year  
1961

5. SEX

M

6. COLOR OR RACE

C

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

8. DATE OF BIRTH

Sept 1877

9. AGE (In years  
last birthday)84  
yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SEAFOOD Worker

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

LITTLETON H. WATERS

14. MOTHER'S MAIDEN NAME

Lucy Wellington

Address

Lucy Randolph Upper Fairmount

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)422.2  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

Bronchial Pneumonia

INTERVAL BETWEEN  
ONSET AND DEATH

3 weeks

DUE TO

(b)

DUE TO

(c)

Chronic myocarditis

6 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year  
Hour a. m. p. m. 1920d. INJURY OCCURRED  
While at work  Not while at work 

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Sept 12, 1961, to Sept 28, 1961, that I last saw the deceased alive on Sept. 27, 1961, and that death occurred at 11:45 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATUREPHYSICIAN'S  
NAME (Type)22a. BURIAL, CREMATION,  
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIAL

22d. LOCATION (City, town, or county)

(State)

Burial

Oct. 2, 1961

Sentinel Cemetery

UPPER Fairmount

Md

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

STATE OF MICHIGAN  
DEPARTMENT OF STATE  
CERTIFICATE OF DEATH

RECORDED IN MICHIGAN

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reached by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, copy the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10684

10678

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>39 CRISFIELD</b>		d. STREET ADDRESS <b>Box 688 CALVARY Rd</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>E.W. McCREADY MEMORIAL HOSP.</b>				d. STREET ADDRESS <b>Box 688 CALVARY Rd</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ETHEL</b>		First <b>ETHEL</b>	Middle <b>Jane</b>	Lost <b>WHITMAN</b>	4. DATE OF DEATH <b>SEPT 3RD</b>	Month <b>19 61</b>	Day Year
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 2, 1888</b>	9. AGE (In years last birthday) <b>73 yrs.</b>	10. IF UNDER 1 YEAR Months <b>73</b>	11. IF UNDER 24 HRS. Hours Min. <b>00 00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>USA CRISFIELD MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>TENNESSEE FLUEHART</b>		14. MOTHER'S MAIDEN NAME <b>HATTIE JANE WHARTON</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mrs. Herman Whitman, Calvary, Crisfield, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <i>Coronary Thrombosis</i> INTERVAL BETWEEN DUE TO <i>immediately</i> ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>420.1</b> <i>Cardiovascular disease</i> <b>3 yrs</b> (b) <i>Hypertension</i> <b>5 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7:00 A.M.</b> to <b>SEPT 3RD 1961</b> , that (I) (we) last saw the deceased alive on <b>SEPT 3RD 1961</b> and that death occurred at <b>7:00 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Sarah M. Peyton</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9-4-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>SARAH M. PEYTON, M.D.</b>		22d. ADDRESS <b>MAIN STREET CRISFIELD, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/7/61</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Asbury Meth. Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>DATE SEP 8 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>

